Pausology

Hormonal Health History

Questionnaire

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This form includes the questions we ask when we meet a new patient in our clinical practice for the first time. Some may feel too personal. That's ok. Skip over any you don't want to answer.

General Info

Name

Age years old

Gender (Female, non-binary, transgender, etc.)

How would you describe your current hormonal phase of life?

- ☐ Premenopause
- ☐ Perimenopause
- ☐ Menopause
- ☐ I don't know

How would you describe your feelings about perimenopause and menopause? *For example, "Overall positive", "Overall negative", "Mixed" or "Neutral".*

What questions or concerns do you have about premenopause, perimenopause and/or menopause?

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Menstrual Cycle History

YOU ARE IN MENOPAUSE

How old were you when entered menopause?

_____ years old

Did your menopause occur after having your ovaries removed?

☐ Yes ☐ No

Did your menopause occur after a medical procedure or treatment? *For example, breast cancer.*

☐ Yes ☐ No

Since menopause have you had any vaginal spotting or bleeding?

☐ Yes ☐ No

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YOU ARE IN PREMENOPAUSE, PERIMENOPAUSE, OR DON'T KNOW

Do you get your period?

☐ YES

If "YES":

When was your last period?

Describe your cycle length or the number of days between the first day of bleeding from one period to the next.

If your cycle length has changed, explain how it has changed. If it hasn't changed, skip to the next question.

Describe your flow or the amount you bleed during your period.

☐ NO

If "NO":

When was your last period?

Have you had your uterus removed?

☐ Yes ☐ No

Do you currently use hormone therapy including pills, skin patches, injections, implants, vaginal rings, or a hormonal IUD (i.e Mirena) for contraception, to manage your menstrual cycle, to manage symptoms of perimenopause, or for any other reason?

☐ Yes ☐ No

Have you been pregnant or breastfeeding within the past 6 months?

☐ Yes ☐ No

Have you had an endometrial ablation within the past 6 months?

☐ Yes ☐ No

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If your flow has changed, please describe how is has changed.

How many days do you bleed during your period?

If the number of days you bleed during your period has changed describe how has it changed?

Do you leak through your menstrual products enough to soak clothes or bed sheets, need to change a soaked pad or tampon every hour for a few hours, or pass clots that are bigger than a quarter?

☐ Yes ☐ No

Do you spot or bleed between periods?

☐ Yes ☐ No

Do you spot or bleed after sexual activity?

☐ Yes ☐ No

Do you experience any of the following before you get your period (mood changes, breast tenderness, headaches, abdominal bloating, nausea, vomiting, cramping, and/or low back pain)?

☐ Yes ☐ No

Have you received or are you currently receiving medical treatment that affects the function of your ovaries?

☐ Yes ☐ No

Do you have PCOS (polycystic ovarian syndrome)?

☐ Yes ☐ No

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Symptoms of Hormonal Change

Please check any that apply to you:

- [ ] I have hot flashes
- [ ] I have night sweats
- [ ] I have heart palpitations
- [ ] I have a hard time falling asleep
- [ ] I wake up in the middle of the night and am awake for an hour or more
- [ ] I wake up very early in the morning and cannot fall back asleep
- [ ] I am experiencing mood changes or swings (i.e. I feel irritable, sad, worried, nervous, jittery, overwhelmed, angry, etc.)
- [ ] I am depressed
- [ ] I am anxious
- [ ] I am forgetful (I can't remember words or where I put things)
- [ ] I have a hard time concentrating
- [ ] I have new dizziness or vertigo (I feel like I'm on a boat)
- [ ] I have more frequent headaches
- [ ] I have breast soreness or tenderness
- [ ] I have gained weight, especially around my belly
- [ ] My vagina (inside body part) is dry and/or irritated
- [ ] My vulva (outside body parts) is dry and/or irritated
- [ ] I am less interested in having sex than I used to be
- [ ] I have a harder time getting sexually aroused (turned on) than I used to
- [ ] I have a harder time reaching orgasm than I used to
- [ ] I have less vaginal lubrication when I am sexually aroused than I used to
- [ ] I have pain in my vagina or around my vulva during sexual activity
- [ ] I feel the need to urinate more frequently
- [ ] I have a sense of urgency when I need to urinate (like I can't hold it in)
- [ ] I have burning when I urinate
- [ ] I leak urine when coughing, sneezing, laughing or jumping
- [ ] I leak urine at other times
- [ ] I feel more tired or fatigued than I used to
- [ ] I have new muscle or joint pain/stiffness
- [ ] I have new digestive issues including bloating, nausea, heartburn, abdominal discomfort, constipation, and/or diarrhea
- [ ] My skin is drier than it used to be
- [ ] My skin is itchier than it used to be
- [ ] I have more breakouts/acne
- [ ] My hair is drier than it used to be
- [ ] My hair is thinner than it used to be
- [ ] More hair falls out than before
- [ ] I have new facial hair

Do you track your symptoms?

- [ ] Yes
- [ ] No

What, if anything, have you tried to find relief from your symptoms? Please note if any treatment(s) have been helpful or not.

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Sexual & Reproductive History

The following questions are intended as a starting point for a conversation about your sexual & reproductive health. We encourage you to share additional information with your healthcare provider.

Do you have sex with a partner(s)? ☐ Yes ☐ No

If yes, is your partner(s) female, male, transgender or other?

☐ Female ☐ Transgender

☐ Male ☐ Other

Do you use birth control to prevent pregnancy and/or a barrier method like condoms to prevent sexually transmitted infections (STIs)?

☐ Yes ☐ No

If yes, what type(s)? *For example, condoms, spermicide, diaphragm, cervical cap, hormonal method (pill, skin patch, injection, implant, vaginal ring, IUD), non-hormonal IUD, fertility awareness method, withdrawal method, tubal ligation, vasectomy*

Are you concerned about your risk of a sexually transmited infection now? *For example, chlamydia, genital warts/HPV, gonorrhea, hepatitis B, herpes, HIV, molluscum, pubic lice, scabies, syphilis, or trichomoniasis.*

☐ Yes ☐ No

Do you masturbate or pleasure yourself sexually? ☐ Yes ☐ No

If you have ever been pregnant, detail the type and number of your pregnancies:

Full term

Premature

Miscarriage

Abortion

Describe any pregnancy, delivery, or postpartum (after birth) related complications you have experienced.

Did you experience significant mood changes including depression and/or anxiety during or shortly after any pregnancy?

☐ Yes ☐ No

In the past have you ever used hormone therapy including pills, skin patches, injections, implants, vaginal rings, creams, gels, sprays, or a hormonal IUD i.e Mirena, for contraception, to manage your menstrual cycle, to manage symptoms of perimenopause or menopause, or for any other reason?

☐ Yes ☐ No

If yes, what type of hormone therapy did you use, why did you use it, and did you experience any side effects while using it?

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Medical History

Please note any medical issues you are currently experiencing or have experienced in the past. *The following list is intended as a guide but is not an exhaustive list. Check any box that applies to you. Use the space at the bottom to include more information including details about the boxes checked.*

- [ ] Anemia
- [ ] Anxiety
- [ ] Blood clot (leg or lung)
- [ ] Cancer
- [ ] Crohn's disease
- [ ] Depression
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Endometriosis
- [ ] Fibroids
- [ ] Gallbladder disease (i.e gallstones)
- [ ] Heart disease including history of heart attack or heart failure
- [ ] High cholesterol
- [ ] High blood pressure
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Lupus
- [ ] Low bone density or osteoporosis
- [ ] Migraine headaches
- [ ] Premenstrual mood disorder
- [ ] Postpartum depression
- [ ] Rheumatoid arthritis
- [ ] Sexually transmitted infection
- [ ] Stroke
- [ ] Thyroid disease
- [ ] Ulcerative Colitis
- [ ] Other:

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Surgical History

Have you had any of the following procedures or surgeries?

- ☐ Both ovaries removed
- ☐ Cervix removed
- ☐ Uterus removed

What other procedures or surgeries have you had?
For example, appendix removed.

Family Medical History

Please include information you know about your biological mother, biological father and any biological siblings. *For example, a history of cancer, blood clot (leg or lung), osteoporosis, hip fracture, heart disease (high blood pressure, high cholesterol, heart attack, or stroke), diabetes, or thyroid disease.*

FAMILY MEMBER	MEDICAL CONDITION(S)	ARE THEY STILL LIVING? IF NOT, CAUSE OF DEATH?
BIOLOGICAL MOTHER		
BIOLOGICAL FATHER		
BIOLOGICAL SIBLING(S)		

Medications & Supplements

Please list all of your current medications and supplements including ones prescribed by a medical provider and any over-the-counter or non-prescription medications, vitamins, minerals, and/or botanicals. *Example: Ibuprofen, 200 mg tablets, Migraines.*

NAME	HOW YOU TAKE IT	REASON FOR TAKING

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Allergies

Please include any known allergies and type of reaction.

Current Healthcare Providers

Please list any healthcare providers from whom you regularly seek care. Include their type of practice, for example “Acupuncturist” or “Nutritionist.”

NAME OF PROVIDER	TYPE OF PRACTICE	CONTACT INFO

Health Screening

Please check any that you have completed within the timeframe indicated:

MEDICAL CONDITION	✓
BLOOD PRESSURE CHECK (WITHIN THE PAST 1-2 YEARS)	
FASTING SUGAR OR A1C CHECK (WITHIN THE PAST 5 YEARS)	
CHOLESTEROL CHECK (WITHIN THE PAST 5 YEARS)	
BONE DENSITY TEST (EVER)	
THYROID FUNCTION CHECK (EVER)	
MAMMOGRAM (WITHIN THE PAST 1-2 YEARS)	
PAP AND/OR HPV TEST (WITHIN THE PAST 3-5 YEARS)	
FIT TEST, SIGMOIDOSCOPY, OR COLONOSCOPY (EVER)	

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Nicotine/Tobacco, Alcohol, & Drug Use

Nicotine/Tobacco

Includes cigarettes, e-cigarettes, vapes, cigars, pipes, and smokeless products.

Please, check all that apply to you.

- [ ] Never use
- [ ] Past use
- [ ] Current use

If you currently use please describe the type, amount, and frequency of your use.

If you currently use, are you interested in cutting back or quitting?

Alcohol

One drink equals 8-12 ounces of beer depending on alcohol percentage, 5 ounces of wine, or 1.5 ounces of distilled spirits.

Please, check all that apply to you.

- [ ] Never use
- [ ] Past use
- [ ] Current use

If you currently use please describe the type, amount, and frequency of your use.

If you currently use, are you interested in cutting back or quitting?

Drugs

For example, cannabis, cocaine/ crack cocaine, heroin, opioids, methamphetamine, or psychedelics including MDMA (Ecstasy), LSD, or psilocybin.

Please, check all that apply to you.

- [ ] Never use
- [ ] Past use
- [ ] Current use

If you currently use please describe the type, amount, and frequency of your use.

If you currently use, are you interested in cutting back or quitting?

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Health Context

Please describe your current living situation including with whom you live.

Please describe your current work situation. *For example, unemployed, employed, retired, on medical leave, permanently disabled.*

If you are currently working, please describe the type(s) of work you do.

Are you currently married or partnered?

Please describe your current support system? *For example, family, friends, work colleagues, or members of a religious/spiritual community.*

Do you have people in your life who depend on you for their financial, emotional, physical and/or other caretaking needs?

Please describe your exercise habits including the type, intensity and frequency of exercise you do in a typical week.

Please describe your nutritional habits including the types of food and beverages (excluding alcohol) you eat and drink over the course of a typical week.

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Do you have any food sensitivities or intolerances?

What do you do to manage your stress or relax?

Please describe any mindfulness activities you practice like meditation, yoga, or breathwork?

Please share any other information you would like your healthcare provider to know about you including any additional questions you have about your health.

What are the current major stressors in your life?

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